

FIDELITY SECURITY LIFE INSURANCE COMPANY

Kansas City, Missouri

Vision Care Plan

{Member}{Employee} Enrollment Form

Name: _____ SS#: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone #: _____ Date of Birth: _____

{E-mail address: _____ }

{Employer Name: _____ }

Dependent Information:

Name	Date of Birth	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

{I AUTHORIZE my employer to deduct my contribution for insurance premium from my wages or salary.}

The Certificate provides Vision Benefits only. Review your Certificate carefully.

{Member}{Employee}
Signature: _____ Date: _____